CHANGING THE TERMS:
HOW COMMUNITIES ARE LEVERAGING HEALTH CARE
FOR PERMANENT SUPPORTIVE HOUSING CAPACITY

BACKGROUND

In 2013 on a given night, 610,000 people were experiencing homelessness in the United States. Around 92,000 are single adults viewed as chronically homeless, meaning they have a disability and history of long or frequent episodes of homelessness. Health care reform can be a significant component of strategies to end chronic homelessness. The Affordable Care Act (ACA) offers needed resources to states and communities struggling to help individuals, solve their homelessness, and strengthen housing stability. As recognized in Opening Doors, the Federal Strategic Plan to Prevent and End Homelessness, delivering on the promises of the ACA calls for partnerships and collaborations at all levels and across the systems that serve people experiencing homelessness. This paper, describing models that have begun to emerge with ACA implementation, is intended to encourage community leaders to consider opportunities and possible next steps to incorporate health care reform in plans to end chronic homelessness.

Addressing the Needs of People Who Are Chronically Homeless

Research shows that people experiencing chronic homelessness are extremely poor and vulnerable, with complex medical, mental health and substance use conditions. These conditions are often co-occurring and may be exacerbated by trauma, injury and physical ailments acquired as a result of homelessness. Despite their severe situations, many chronically homeless people are unable for various reasons to access disability

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Five Communities – Models of Collaboration

**Chicago** – Network of diverse service providers using new health care resources to reorganize safety net for vulnerable populations, including people who need supportive housing. Together4Health, Appendix, Page 10.

**Cleveland** – New and renewed partnerships focus on bringing primary care to supportive housing, strengthening recovery of people who have experienced chronic homelessness. Housing First, Appendix, Page 11.

**Minneapolis** – Homeless services agency teams up with Medicaid managed care organization to integrate housing, primary care and behavioral health for Medicaid enrollees experiencing chronic homelessness. Medica Supportive Housing Initiative, Appendix, Page 12.

**Philadelphia** – City agency leverages Medicaid funding in strategy to house and support people with behavioral health conditions who need housing to recover. Department of Behavioral Health and Intellectual disAbility, Appendix, Page 13.

**Portland, OR** – Housing and service providers partner with Medicaid managed care plan to coordinate primary care and long-term supports to end chronic homelessness. HSO, Appendix, Page 14.
programs such as Supplemental Security Income and Medicaid long-term services and supports. Without any resources, especially health care coverage, they frequently delay seeking care until they are very ill. As a result, people experiencing chronic homelessness are heavy users of costly emergency services and hospital care.

There is widespread agreement among policy experts that permanent supportive housing (PSH) is the answer for people who are chronically homeless, and for the safety net systems that serve them. Permanent housing provides a safe setting for recovery and achieving the highest levels of independence in the community. However, housing alone is not sufficient; it must be accompanied by appropriate, voluntary supports – including access to adequate primary and behavioral health care and intensive community-based supports. Research has also shown that PSH is a sound investment for communities, leading to public savings and efficiencies for those with permanent disabling conditions.¹

Federal policy recognizes the value of PSH for the most vulnerable people experiencing homelessness. However, targeted federal housing resources remain scarce, and communities face significant challenges to develop and sustain the most effective models of PSH to end chronic homelessness.

Opportunities Under Health Care Reform

Certain aspects of health care reform present real opportunities to augment PSH resources and accelerate solutions to chronic homelessness. Taking advantage of these opportunities requires communities to incorporate health care reform into their plans to end homelessness and to act accordingly. Relevant health policy changes for homeless assistance are summarized below.

Medicaid Expansion. The Affordable Care Act of 2010 (ACA) prompts changes in the way communities serve vulnerable people experiencing homelessness. The most important is states’ option to expand Medicaid with generous federal subsidies to cover poor adults – in effect reaching all chronically homeless individuals not already eligible by reason of disability. As a result of a Supreme Court decision in 2011, states can choose to take on this new Medicaid population, but may not be required to do so. When this key provision takes effect in early 2014, around half the states will have opted to expand.

Medicaid expansion under the ACA has implications for ending chronic homelessness on two levels. First, it provides a core set of benefits – including behavioral health coverage – to individuals who have long been excluded from health care insurance. With full state participation, Medicaid would cover up to 16 million more people who are now uninsured. Actual benefits will vary from state to state, within a broad federal framework. In some states, basic Medicaid benefits will be more generous and comprehensive than in other states, as is true of Medicaid generally. Therefore many experts predict that very vulnerable people will continue to face barriers to appropriate health care. Nonetheless, in states that do expand Medicaid, chronically homeless people will have more access to medical services, preventive care, and behavioral health to address mental health and substance use disorders.

Second, coverage for the expanding eligibility group means an influx of Medicaid dollars to local service systems, creating strategic opportunities to reset state and local safety-net funding priorities. For example, as more clinical services are reimbursed by Medicaid instead of local general funds, a county mental health department could use those local funds to offer more rental subsidies, or increase case management in supportive housing. Other federal funding, such as substance abuse and mental health block grants, could also be repurposed in targeted ways.

**Community-Based Services and Supports.** Apart from expanding the number of people in Medicaid, the ACA expands capacity for communities to serve and support people with disabilities and other vulnerabilities. Very generally, these include a menu of state options and incentives for Medicaid home and community-based services (HCBS), and more funding for community-health centers, among other provisions. With appropriate federal and state approvals, Medicaid HCBS can fund a number of long-term services and supports that have not traditionally been considered “medical” for the purposes of Medicaid coverage. Community health centers, with long experience and competence meeting the needs of underserved populations, will be critical points of access for new Medicaid enrollees with high health risks, as well as those who continue to be uninsured.

**Health Homes.** To address chronic homelessness and enhance supportive housing, one promising new state option is a voluntary care coordination program for Medicaid enrollees with severe mental illness or other chronic disabling conditions. Known as a health home, this benefit reimburses qualified providers for some of the tasks of organizing the diverse services needed to stabilize people with complicated health care needs. States have flexibility in how they design health homes. In some states, Medicaid health homes are a function of mental health departments. In others, community health providers – including those that offer supportive housing – can be eligible for the program.

**Mental Health Parity.** Another important federal health policy that will be implemented along with the ACA is behavioral health parity under the Mental Health Parity and Addiction Equity Act of 2008. This law is expected to elevate and standardize coverage of mental health and addiction treatment, relative to other health benefits. New Medicaid benefits for the expanded population group are required to meet parity standards.

**Overall Policy Directions.** Health policy analysts refer to the “triple aim” of the ACA, in that the goals of the legislation as a whole are to increase access, improve quality, and lower total health care costs over time. The triple aim will guide ACA implementation in how delivery systems will be given new resources and how their outcomes will be evaluated.

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FIVE COMMUNITIES: CHANGING THE TERMS

In July 2013, the National Alliance to End Homelessness convened a panel and discussion titled “Changing the Terms: How Communities are Leveraging Health Care for Permanent Supportive Housing Capacity.” Initiatives in Chicago, Cleveland, Minneapolis, Philadelphia, and Portland (OR) were highlighted as examples of integrating health care opportunities with strategies to end homelessness. Representatives from each community made presentations and offered remarks on implications for PSH capacity. This section summarizes the substance of the presentations and discussion.

Efforts in the five communities vary in scope and scale. In two communities, for example (Chicago and Portland), multiple stakeholders have forged new delivery systems with the recognition and support of their respective state Medicaid programs. In contrast, the Medica Supportive Housing Initiative (Minneapolis) reflects a more limited collaboration among a few key partners. Cleveland and Philadelphia, in states that had not opted by July 2013 to expand their Medicaid programs, illustrate in different ways what can be done in a non-expansion state. What they all have in common is the goal of integrating housing and health care as a strategy to address chronic homelessness. For more information about strategies in each of the five communities, see Community Profiles in the Appendix.

Collaborative Responses for Supportive Housing Strategies

As summarized above, the ACA has real potential to help the most vulnerable people experiencing homelessness by expanding their access to needed services. Responses in the five communities suggest deeper implications for local systems of care and strategies to end chronic homelessness. In particular, housing and service resources can be re-arranged in new combinations to bolster supportive housing. Funding from various sources can also be re-allocated across a network or system, resulting in new housing capacity.

Areas of innovation and activity that emerged in “Changing the Terms” include use of Medicaid health homes; strengthened participation of federally-qualified health centers (FQHCs); integration of community behavioral health programs; engagement of housing providers; and flexible use of Medicaid savings. These activities are outlined below.

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3 The morning was co-sponsored by the U.S. Interagency Council on Homelessness and 100,000 Homes. The Alliance is grateful for the participation of all the speakers: Richard Cho, USICH; Karen Batia, Together4Health; Marcella Maguire, Philadelphia Department of Behavioral and Intellectual disAbilities; Carol Wilkins, Consultant; Rachel Post, Central City Concern; Traci Manning, Portland Housing Bureau; Bethany Graham, Enterprise Community Partners; Eric Morse, Frontline Service; Richard Wayman, (formerly) Hearth Connections. Presentations are available on the Alliance’s website at http://www.endhomelessness.org/library/entry/changing-the-terms-how-communities-are-leveraging-health-care-for-psh-capac

4 By the end of 2013, Ohio had decided to expand Medicaid and Pennsylvania appeared to be moving in that direction.
**Medicaid Health Homes.** In three of the five communities, the ACA offers new funding for coordinating various services and interventions under the health home benefit for vulnerable Medicaid enrollees.

- In Chicago, Together4Health is creating health homes as actual service hubs located in neighborhoods where vulnerable enrollees are concentrated.
- A core aspect of the partnership in Cleveland between Frontline Service and Care Alliance is for Frontline Service to qualify as a health home for tenants in supportive housing.
- Central City Concern is a designated health home provider in Oregon, enhancing its ability to coordinate care for the homeless Medicaid population in Portland.

Minnesota and Pennsylvania do not offer a Medicaid health home benefit, though Minnesota was pursuing the option as of the end of 2013. However, both Hearth Connections (Minneapolis) and the city of Philadelphia utilize their own care coordination strategies in homeless assistance, and could eventually benefit from Medicaid health home reimbursement in their states.

**Role of Community Health Centers.** Health Care for the Homeless projects and FQHCs generally have long been principal providers of health care services to underserved and uninsured populations. In new strategies for addressing the needs of chronically homeless people, FQHCs are often leading partners, contributing service capacity and clinical expertise to integrated approaches. Collaborative models vary. In Chicago and Portland, for example, FQHCs are members of formal networks. In Cleveland, the Housing First collaboration is bringing health care to its PSH tenants through a new partnership with the FQHC Care Alliance.

**Integrated Behavioral Health.** Like FQHCs, community mental health centers are traditionally primary providers of services to chronically homeless people. They also play important roles as partners in new strategies that integrate supportive housing with physical and mental health services, and behavioral health treatment and recovery support. As a result, integrated networks have access to behavioral health resources from various sources.

- Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), for example, support homeless outreach and enrollment in Together4Health (Chicago); expedited access to benefits and peer supports in Portland’s HSO; and housing support and other activities in the Cleveland where a behavioral health organization is a lead agency in the Housing First collaborative.
- Supportive services for clients in the Hearth/Medica initiative (Minneapolis) are partly funded through a Medicaid benefit specifically for behavioral health providers.
- Philadelphia’s Department of Behavioral and Intellectual disAbilities manages multiple funding streams to meet the behavioral health and related needs of chronically homeless people.

**Engaged Housing Partners.** The five communities actively involve housing providers in community health strategies, with the specific objective of meeting the needs of chronically homeless people.

- Together4Health (Chicago) and HSO (Portland) represent a system-oriented model. In both places, the health care networks include housing providers among a diverse base of community
partners, all with commitments to the overall goals of the initiatives. This in itself gives the networks some housing capacity.

- In Portland, city and county leaders have also made commitments to add housing resources, based on projections of savings to local service budgets from HSO activities. These might be used, for example, to pay for short-term rental assistance after an institutional stay, until PSH subsidies are obtained.
- In addition to managing its own housing resources, the Philadelphia Department of Behavioral and Intellectual disAbilities has access to Public Housing Authority units, as a result of inter-departmental collaboration.

**Medicaid Capitated Payment: Opportunity to Share in Savings.** As already noted, PSH is proven effective for people and community-based systems that serve them. Yet because of health policies and program silos, communities are typically restrained from capturing Medicaid savings for non-Medicaid uses, even when outcomes could be further improved. The ACA can soften some of these limitations, allowing Medicaid to be used more flexibly, along with other programs savings.

Together4Health in Chicago and HSO in Portland are examples. In both locations, Medicaid state agencies are stakeholders, agreeing with community partners that more collaborative ways of serving vulnerable people can result in overall savings. Illinois and Oregon officials therefore approved and promoted new service networks designed to identify and more effectively serve the most costly, highest users of Medicaid. Each network, as a separate risk-accepting entity, will have set Medicaid payments and other funding to accomplish these objectives. Funding the network in this way requires partners to collaborate in managing costs of serving the covered population.

Philadelphia reflects a different model, but demonstrates a similar strategy. There, city government is accountable for housing and service integration, leveraging revenues from the Medicaid Managed Care Organization (MCO) that finances behavioral health – along with other resources. The MCO is a local non-profit entity reporting to the city’s Department of Behavioral Health.

In all three communities, explicit state authority is required to leverage Medicaid savings. Illinois and Oregon, especially, have been active in seeking and obtaining federal Medicaid resources and approvals to support innovation in health care delivery. It is very early in implementation, and results cannot be shown or fully analyzed at this time.

Leveraging Medicaid for housing, specifically, can be a further challenge. Once federal Medicaid waivers and necessary state approvals are in place, decisions to fund supportive housing – or not – are made collaboratively at the network level. Housing providers are represented differently in the formal network governance of HSO compared to Together4Health.

The Medica Supportive Housing Initiative (Minneapolis) is an example of how a relatively simple collaboration can translate to housing for chronically homeless Medicaid enrollees, without the need to create independent networks under the oversight of Medicaid authorities. With this model, a homeless
assistance agency leverages its expertise and its specialized provider relationships to attract the additional health care resources of a Medicaid MCO. The Medicaid MCO in turn has access to housing solutions for its most vulnerable homeless, highest-cost enrollees. Though it began as a pilot with a set capacity of 85 clients, the initiative can expand over time, or be replicated by other providers and MCOs across Minnesota.

Enhancing PSH Effectiveness. In Cleveland, leaders honed in on ACA opportunity as a vehicle to advance an ongoing plan to end chronic homelessness. The Housing First collaborative has forged new relationships and programs to improve housing outcomes for the vulnerable people already in PSH. The ACA has spurred new partnerships with the FQHC CareAlliance, allowing integration of health care services at the PSH sites. The partnership brings new service resources and strengthens the overall collaborative capacity of the Housing First plan to end homelessness. As a result, the community attracted additional support from the state housing finance agency to offer mobile health services for PSH tenants. Further, an integrated model will be in place as the state implements its Medicaid expansion.

Improved health outcomes support housing stability and retention, which is part of PSH capacity building. The Housing First collaborative anticipates that some tenants recovering in PSH will fare well enough eventually to choose other housing in the community, making more supportive housing available.

MOVING FORWARD: EMERGING CHALLENGES

Experiences in the five communities point to some common challenges as well as opportunities for integrating health care reform in strategies to end homelessness. Three areas that may present threshold challenges in other communities are relationships with Medicaid authorities; health care payment policies; and data strategies.

Medicaid Policies. Clearly the most critical factor is the role of Medicaid policy at federal and state levels. Federal policy is driving expansions in Medicaid eligibility, which in turn is driving innovation in communities like Chicago and Portland. In the first year, 2014, about half the states are expanding. The opportunity will remain open to the remaining states for the foreseeable future. Communities striving to end chronic homelessness hold considerable stakes in these future state policy decisions.

In addition, the ability to use Medicaid flexibly in community networks depends on federal waivers granted to state Medicaid programs, as the projects in Chicago and Portland show. Communities need state Medicaid officials to apply for and administer the waivers that fully support community designs. Similarly, state-level Medicaid decisions also influence whether benefits like Medicaid health homes will be effective in serving homeless populations.
The Case for Adequate Coverage and Reimbursement. Communities face challenges engaging Medicaid leaders on reimbursement issues relating to supportive housing solutions. Adequate coverage and payment policies are needed for the person-centered supportive services needed in PSH – including street outreach, peer-delivered services, home visits and homemaking assistance, case management, and effective behavioral health services in the community. However, states and payment intermediaries like MCOs may not understand PSH and the specific services required to effectively support PSH tenants. People experiencing chronic homelessness often need intensive services to make PSH a cost-effective intervention over the long term. PSH providers also need stable funding for these services. However, whether they can bill Medicaid directly as health care providers depends largely on state Medicaid administration. In the dynamics of state and federal Medicaid policy, these have to be ongoing discussions and themes.

Housing and Health Care Data. Access to useful data is especially challenging in the context of health care delivery. PSH strategies need to consider how clinical data can be shared among providers, as well as the data analysis needed to show health and housing outcomes. In the health care system, there may be specific legal and technical barriers, as well as general privacy concerns and provider policies to overcome. The ACA offers some policy support to improve data management in Medicaid programs. For instance, Medicaid health home providers have to meet certain standards in how they handle and share health information to promote service coordination. Merging homeless assistance data with other program information remains a challenge. Federal and state policy solutions are needed, and are slow in coming. In the meantime, community solutions depend on collaboration at high levels. Promising approaches, best practices, and policy options in this area are important areas for future study.
APPENDIX
Community Profiles

Together4Health – Chicago

Housing First – Cleveland

Medica Supportive Housing Initiative – Minneapolis

Department of Behavioral Health and Intellectual disAbility – Philadelphia

HSO – Portland, OR
Together4Health – Chicago

In Chicago, a diverse group of health care providers led by the nonprofit Heartland Alliance has formed a network to serve very vulnerable Medicaid enrollees, including people experiencing or at risk of chronic homelessness. Together4Health consists of 5 Chicago-area hospitals, 8 federally-qualified health centers (FQHCs), 11 behavioral health agencies and a number of community-based organizations offering services and programs in housing, food and nutrition, supported employment, and other areas. Its mission is to reach and serve vulnerable people who use Medicaid services at unusually high rates.

Together4Health is a “coordinated care entity” (CCE) approved by the state of Illinois under a federal Medicaid waiver. As a CCE, Together4Health is designed as a Medicaid risk-based network, meaning that it is obligated to serve its clients appropriately within a set amount of Medicaid funding. (In contrast, a non-risk method can be open-ended, paying providers by items of service or units of time.) As a risk-based network, Together4Health must manage its collective resources effectively to meet the needs of the individuals making up the enrolled population. Illinois Medicaid has an ongoing oversight role to assure quality and measure outcomes.

Clients are drawn from the Medicaid client base of partner organizations. The CCE has a targeting strategy, which includes use of client data across providers, to identify their highest users of relatively costly care such as emergency services and inpatient hospital stays. Once they are engaged, Together4Health enrollees are offered coordinated, comprehensive care based on their needs. By delivering person-centered care to very vulnerable enrollees, Together4Health aims to improve their health outcomes and quality of life in the community. The strategy is based on the proposition that better access to timely coordinated services will lead to cost-efficiencies and ultimately net revenue margins for the organization. As a result, the CCE can devote additional resources to non-Medicaid programs and services that are proven contributors to the desired client outcomes.

Housing providers and housing-related services are represented in Together4Health leadership and are part of the mix of services available. Supportive housing is a possible intervention, especially for Medicaid enrollees who are also chronically homeless. The services Together4Health can coordinate and deliver as a single agency — medical, behavioral, psychosocial — are proven effective in helping vulnerable homeless people recover and thrive in permanent housing. Thus the CCE creates a collaborative framework to maximize housing capacity for homeless and at-risk enrollees.

Together4Health is starting with funding from various sources, including financial stakes from its partner organizations. However, as part of its relationship to Illinois’ Medicaid program, the CCE is expected to operate at full risk, sustainably, within two years of its official start. Together4Health forecasts total savings of $11 million over three years.

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5 A Medicaid waiver gives federal administrative approval for a state to depart from selected Medicaid rules and requirements, e.g., in order to test innovations in financing or service delivery. See also footnote 6.

6 Illinois is expanding Medicaid eligibility under the ACA in 2014, which will increase the potential client base and help fund additional capacity for Together4Health.
Housing First – Cleveland

Ohio was relatively late in making a final decision to expand Medicaid under the ACA for 2014. (See footnote 4, above.) Earlier, however, the state sought and received approval for a Medicaid health home program, to coordinate services for its existing Medicaid behavioral health population. In this environment, community partners in Cleveland are forging new collaborations to strengthen existing PSH capacity and tenant outcomes, and be ready for Medicaid expansion. Leaders in this effort are PSH developer Enterprise Community Partners and community behavioral health agency Frontline Service (formerly Mental Health Services Inc.), working together with other partners in a larger project, Housing First of Cuyahoga County.

Frontline Service screens and places people in PSH, serving them with behavioral health care and case management, funded from various public and private non-profit sources. To date, Frontline by itself has not fully been able to meet the medical needs of its highly vulnerable PSH population. Cleveland Housing First tenants, like many people with histories of chronic homelessness, have high rates of chronic illness along with severe mental illness, often with co-occurring substance use disorder. Roughly half are enrolled in Medicaid because of qualifying disabilities; otherwise, they have been uninsured but may now enroll in the expanded Medicaid program. Most lack a regular primary care provider and may delay medical treatment until their conditions require urgent care. Thus they are frequent users of emergency services. Cleveland also has federally qualified health centers (FQHCs), including a Health Care for the Homeless project, serving PSH tenants and other vulnerable homeless clients.

Prompted by the passage of the ACA in 2010, Enterprise and Frontline approached health care safety net providers in Cleveland in search of ways to improve tenants’ access to health care and integrate services across silos of funding and providers. One outcome is a stronger partnership with Care Alliance, an FQHC that has experience serving the same population served by Frontline. Frontline and Care Alliance have put together housing, behavioral health, primary care, and other needed services to support Housing First tenants. With input from outside expertise, Frontline has become qualified to be a health home in Medicaid, coordinating services for people with severe behavioral health conditions. In this role, Frontline can devote staff to assessing tenant needs, organizing an array of community services, and providing the ongoing person-centered supports for tenants to have the best outcomes possible in supportive housing.

The participation of Care Alliance is key. Frontline is facilitating the health center’s evolving role as a designated primary care provider to Housing First clients. Staff and leadership from both agencies are working in teams, both to serve clients and to overcome organizational barriers. The partnership was recently awarded a grant from the state housing finance agency to invest in and operate a mobile health unit so that tenants can choose to access care where they live. As Ohio Medicaid moves forward to cover all Housing First tenants, Frontline and Care Alliance is prepared with an integrated strategy to meet new funding opportunities. The partnership will also be able to re-align services and funding to fill any gaps in coverage and eligibility.
Medica Supportive Housing Initiative – Minneapolis

Hearth Connection, a Minnesota homeless services organization, is working closely in the Minneapolis area with a Medicaid health plan, Medica, to address chronic homelessness and improve quality and cost efficiencies in health care. Hearth Connection, with a mission to end long-term homelessness, is the local intermediary that manages and distributes housing assistance from various federal and state sources. The organization also promotes best practices among homeless assistance providers and collects program data to track outcomes and guide strategies to end homelessness. Medica is a health care plan under contract with the state to manage and pay for covered services to people in the state’s Medicaid program.

As a managed care organization (MCO)\(^7\), Medica has a set amount of Medicaid funding and negotiates with health care providers to meet all its enrollees’ needs within its overall budget. The Medica Supportive Housing Initiative combines resources and expertise from Hearth Connection and Medica. Initially, the partnership is committed to housing and serving 85 Medicaid enrollees who were identified as both homeless and high users of crisis and emergency medical services, and inpatient hospitalizations. The arrangement took shape when Minnesota opted to expand Medicaid before 2014 under a special provision of the ACA. At that time, Medicaid MCOs had an influx of new enrollees, particularly non-parent adults who were previously ineligible and uninsured. Hearth Connection was able to share its experience with effective supportive housing strategies that reduce public costs associated with chronic homelessness. Medica agreed to find and refer to Hearth Connection its most vulnerable homeless enrollees who wanted to participate in the three-year initiative.

After a person is placed in supportive housing, the Medica/Hearth Connection collaboration continues. Medica pays under its MCO contract for primary care and for service coordination within the bounds of Medicaid coverage. Hearth Connection uses its relationships with community providers to arrange for additional wrap-around services, such as case management for behavioral health, to support recovery and housing stability. As the principal point of funding and oversight, Hearth Connection collects and analyzes data from participating entities, and is able to track outcomes and recommend further interventions if needed.

\(^7\) MCOs are health plans that are under state contract to provide Medicaid benefits to enrollees for a set capitated payment amount.
Department of Behavioral Health and Intellectual disAbility – Philadelphia

The city government in Philadelphia is managing its resources across silos to integrate housing and behavioral health treatment and supports for vulnerable people experiencing homelessness. A critical component is the city’s direct management and control of Community Behavioral Health (CBH). CBH is a not-for-profit MCO, covering behavioral health, case management, and other services to Philadelphia’s Medicaid enrollees. As an MCO, CBH has a set amount of Medicaid funding and negotiates with health care providers to meet enrollees’ behavioral health needs within its overall budget.

CBH is part of the Department of Behavioral Health and Intellectual disAbilities, which also manages the city’s behavioral health services for people experiencing homelessness, along with city’s office of supportive housing. With this organizational structure, one city administrator oversees funding from diverse sources, including Medicaid. The Department is able to combine resources from different streams to meet clients’ overall needs, including supportive housing. Extra revenue is available to the extent that the city manages the Medicaid MCO with a surplus.

Because of its integrated structure, the Department has more capacity to address chronic homelessness with housing options and supportive services. Specific strategies include street outreach, short-term safe haven options, targeted substance abuse treatment programs, supportive housing, and case management across programs, including in city-funded shelters. Supportive housing units are funded by the behavioral health department (600 units) and commitments from the housing authority (1,000 units), in addition to the 2,000 units paid for by the federal McKinney-Vento program. Philadelphia’s recent progress reducing its number of people experiencing homelessness includes a 70 percent decrease in persons with serious mental illness.

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8 See footnote 4.
9 The city is authorized to operate the MCO for behavioral health services by the state of Pennsylvania. Other MCOs in the Philadelphia area have contracts for medical services.
Central City Concern/HealthShare – Portland, OR

Supportive housing for vulnerable people experiencing homelessness is one component in a concerted strategy to reduce Medicaid and other health care costs in Portland, Oregon. In the Portland area, homeless services provider Central City Concern is part of Health Share of Oregon (HSO), a coordinated care organization (CCO) that is substantially funded by Medicaid. As a CCO, HSO is risk-based, with a pooled annual budget. Collectively, HSO’s 11 founding board member organizations are responsible for identifying and serving vulnerable Medicaid enrollees, and reducing overall Medicaid costs in the community.

Central City Concern is a nonprofit agency serving single adults and families in the Portland metropolitan area who are affected homelessness, poverty and often complex health and behavioral health conditions. Central City Concern is a federally qualified health center (FQHC) integrating a comprehensive range of housing options with direct social services including primary care, recovery and employment. It serves 13,000 individuals annually, many of whom are frequent users of hospitals and emergency departments in the absence of effective supportive housing. With its own supportive housing capacity and a history of success at addressing chronic homelessness in Portland, Central City Concern is seen by its HSO partners as uniquely qualified to deliver services to this group in a cost-effective manner. Many clients are uninsured but will become eligible for Medicaid effective January 1, 2014, as Oregon has chosen to expand Medicaid under the ACA.

As one of the founding HSO members, Central City Concern reinforces the significant role supportive housing plays in meeting the health care needs of very vulnerable people experiencing homelessness, while helping to meet overall objectives to reduce their Medicaid costs. At the same time, HSO strategies are projected to reduce non-Medicaid costs now borne by the city and three surrounding counties. These savings to local mental health, public health, and public safety systems can translate to added housing capacity, making HSO approaches sustainable over time.

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10 A CCO is a health care network that includes entities that pay for health care, such as Medicaid MCOs and local health departments, as well as providers such as hospitals and community health centers. The key difference between a CCO (e.g., CareSource in Portland) and a CCE (e.g., Together4Health in Chicago) is that the Portland CCO network includes a Medicaid MCO, while the CCE consists of providers only. In Oregon, Medicaid operates through MCOs, which do business with the state. In Illinois Medicaid uses a fee-for-service approach to paying for health care, and does not sponsor MCOs. See footnote 1 and accompanying text.